CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00151/4

TITLE: Tennessee TennCare Demonstration

AWARDEE: Tennessee Department of Finance and Administration

1. All contracts and modifications of existing contracts between the State and managed care organizations (MCOs) or Behavioral Health Organizations (BHOs) must be approved by CMS prior to the effective date of the contract or modification of an existing contract. In addition, for any contract in which there exists a clause allowing cost effective alternatives, alternative services that were not included in the list submitted by the State to CMS on April 11, 1996 must be approved in advance by CMS. No Federal financial participation (FFP) will be available for any contract, modification, or services not approved by CMS in advance of its effective date, or in the case of services, the date of use. Within 30 days of the receipt of a complete and final document, CMS will either approve the document or notify the State of issues that will require additional discussion.

2. The State shall prepare one Operational Protocol document that represents the policy and operating provisions applicable to this demonstration which have been agreed to by the State and CMS. The State must submit this protocol to CMS no later than 90 days after implementation. CMS will respond within 45 days of receipt of the protocol. If CMS requires any changes to the initial Operational Protocol, the State will discuss required revisions with CMS and develop revisions acceptable to CMS within 45 days thereafter. During the demonstration, subsequent changes to the protocol should be submitted on an ongoing basis no later than 90 days prior to the date of implementation for approval by CMS. A number of Special Terms and Conditions include other information and requirements which also should be included in the protocol. Attachment A is an outline of all the areas that must be covered in the protocol.

3. Not later than 90 days prior to implementation of an employer sponsored health insurance subsidy program, the State shall submit an addendum to the Operational Protocol describing how the program will operate, the phase-in process, and how the State will monitor to assure that covered employer sponsored programs meet all requirements for participation in the program. The addendum must be reviewed and approved by CMS prior to implementation.

4. The State will conduct beneficiary surveys each operational year of the demonstration. The State shall conduct a statistically valid sample survey of all TennCare enrollees. The survey will measure satisfaction and include measures of out-of-plan use, average waiting time for physician office visits, and the number and causes of disenrollment. Results of the survey and an electronic file containing the raw data collected must be provided to CMS by the ninth month of each operational year. The CMS project

officer must approve the survey and sampling methodology in advance. Within 30 days of the receipt of a complete and final document, CMS will either approve the document or notify the State of issues that will require additional discussion.

5. The State shall require all providers to submit data as defined in the minimum data set submitted to CMS in project year one. The State must perform periodic reviews, including validation studies, in order to ensure compliance. The State shall have provisions in its contracts with health plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. If the State fails to provide accurate and complete encounter data for any managed care plan, it will be responsible for providing to the designated CMS evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.

6. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must focus on the following priority areas:

   Childhood immunizations
   Prenatal care and birth outcomes
   Pediatric asthma
   Two additional clinical conditions to be determined by the State based upon the population(s) served

7. The State must fully meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B, for contracting with MCOs.

8. The State shall require health plans to contract with Federally Qualified Health Centers (FQHCs). If FQHCs implement their own managed care plan, other managed care plans in the same service area will not be required to contract with FQHCs. If a managed care plan can demonstrate to the U.S. Department of Health and Human Services and to the Tennessee Department of Human Services that both adequate capacity and an appropriate range of services for vulnerable populations exists to serve the expected enrollment in a service area without contracting with FQHCs, the plan can be relieved of this requirement.

9. The State must develop internal and external audits to monitor the performance of the plans. At a minimum, the State shall monitor the financial performance and quality assurance activities of each plan. Upon request, the State will submit to the Project Officer and to the CMS Regional Office copies of all financial audits of participating health plans and quality assessment reviews of these plans.

10. The allowable disbursements from the supplemental pools described in General Financial Requirements Under Title XIX (Attachment D) items 5.b. and 5.c. are limited to the categories and amounts disbursed in SFY 2002 except that the Special Hospital Payments supplemental pool is limited to $100 million in each demonstration year and the Critical Access Hospital supplemental pool is limited to $10 million in each demonstration year. The State may request approval to make disbursements from the supplemental pools in excess of the amounts disbursed in SFY 2002. The State

must submit a request to change supplemental funding pools, which details any changes to supplemental funding pools, including the State's intention to begin or end payments from these pools. A detailed and specific description of the source of pool funds, how payment amounts will be determined, how payments will be made, and what audit trail will exist, must be provided. The State will not make payments from a supplemental pool until CMS has approved the supplemental pool payment methodology change and documentation. If the State makes pool payments to Critical Access Hospitals, those payments will be included in the demonstration budget neutrality test. CMS reserves the right to deny approval of increases to payments from supplemental pools, even if approval would not compromise budget neutrality.

Because of the flexibility provided to the State by this demonstration, Federal matching funds must be accounted for in a manner which CMS agrees provides assurance that these Federal funds are not used as the State share for additional expenditures.

11. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after July 1, 2002, to the extent that the changes are applicable to programs being operated under section 1115 demonstration authority. If the change requires a reduction in federal financial participation in expenditures under such a demonstration, the State will adopt, subject to CMS approval, modified budget limits for TennCare as necessary to comply with such change. The modified budget limit would be effective upon implementation of the change in Federal law, as specified in the law.

12. Tennessee must maintain procedures so that hospitals will be able to distinguish individuals who are eligible under current law from individuals who are only eligible because of the demonstration.

13. The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The reports should include a discussion of events occurring during the quarter that affect health care delivery, quality of care, access, financial results, benefit package, and other operational issues. The report should include a separate discussion of State efforts related to the collection and verification of encounter data. The report should also include proposals for addressing any problems identified in the quarterly report. Utilization of health services based on encounter data should be reported on a quarterly and cumulative basis by health plan. At a minimum, this should include physician visits, hospital admissions, and hospital days per 1,000 member months, broken out by pregnant women, other adults, and children.

14. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of each calendar year of operation. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

15. During the last 6 months of the demonstration, no enrollment of individuals who would not be eligible under current law will be permitted.

16. Tennessee will implement modifications to the demonstration by submitting revisions to the original proposal for CMS approval. The State shall not submit amendments to the approved State plan relating to the expansion populations.

17. The State must continue to ensure that an adequate Medicaid Management Information System (MMIS) is in place and provide evidence of such to CMS upon request. One feature of the system must be to report current enrollment by plan and Medicaid eligibility group (MEG).

18. The State must assure that its eligibility determinations are accurate.

19. The CMS project officer or designee will be available for technical consultation at the convenience of the awardee within 5 working days of telephone calls and within 10 working days on progress reports and other written documents submitted. The State will be similarly available for consultation with CMS.

20. A draft final report should be submitted to the CMS project officer for comments. CMS comments should be taken into consideration by the awardee for incorporation into the final report. The final report is due no later than 90 days after the termination of the project.

21. CMS may suspend or terminate any project in whole, or in part, at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal closeout costs.

22. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS project officer shall <u>not</u> direct the interpretation of the data used in preparing these documents and reports.

23. The awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.

24. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must submit to CMS analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired, or generated under the award and/or data furnished by CMS. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the principal investigator and the CMS project officer. The negotiated

format(s) could include both file(s) that would be limited to CMS internal use and file(s) that CMS could make available to the general public.

25. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must deliver to CMS any materials, systems, or other items developed, refined, or enhanced in the course of or under the award. The awardee agrees that CMS shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal Government purposes.

26. Prior to the start date of delivery of services by any MCO or BHO in any area of the State, the State must submit evidence that the managed care organization(s) capacity is adequate in that area of the State to serve the expected enrollment. CMS will base its evaluation of adequacy on the access standards in Attachment C. Copies of the individual provider agreements with the managed care organizations shall be provided to CMS, if requested.

27. For the duration of the State's "Stabilization Plan" period, in which MCOs operate under non-risk contracts, the annual federal cost of TennCare II, exclusive of supplemental payments to providers, may not exceed in the aggregate the federal share of the budgeted cost for MCO payments in state fiscal year 2003 (exclusive of supplemental payments to providers) as set forth in the most recently agreed upon estimates in the budget neutrality portion of the TennCare waiver negotiations. For any Stabilization Plan period after state fiscal year 2003, the budget limit will be adjusted for inflation using the trend factors contained in the State's with-waiver calculation for MCO payments, and will be prorated to the extent the Stabilization Plan period is less than a full state fiscal year.

Attachment A

TennCare
Outline for Operational Protocol

Tennessee will be responsible for developing a detailed protocol describing the TennCare demonstration. The protocol is a stand-alone document that reflects the operating policies and administrative guidelines of the demonstration. The State shall assure and monitor compliance with the protocol. Areas that should be addressed in the document include:

1. organizational and structural configuration of the demonstration arrangements
2. organization of managed care networks
3. payment mechanism
4. benefit packages
5. TennCare eligibility process
6. marketing and outreach strategy
7. enrollment process
8. quality assurance and utilization review system
9. grievance and appeal policies
10. administrative and management system
11. encounter data
12. federally qualified health centers
13. financial reporting
14. eligibility criteria

15 cost sharing

Attachment B

Monitoring Budget Neutrality for the TennCare Demonstration

The following describes the method by which budget neutrality will be assured under the TennCare demonstration beginning July 1, 2002. In general, Tennessee will be using a per capita cost method, and demonstration budget targets will be set on a yearly basis, with a cumulative five-year budget limit.

Individuals who are eligible under the demonstration will be one of three types: (1) those who are currently eligible under Tennessee's existing Medicaid State plan; (2) those who could be eligible for Medicaid if Tennessee amended its State plan; and (3) those who could not be eligible without section 1115 authority. Tennessee will be at risk for the per capita cost (as determined by the method described below) for current eligibles (as defined by groups 1 and 2 above) but not at risk for the number of current eligibles. By providing FFP for all current eligibles, Tennessee will not be at risk for changing economic conditions. However, by placing Tennessee at risk for the per capita costs for current eligibles, CMS assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration. Tennessee will be at risk for both enrollment and expenditure growth for demonstration eligibles who could not be eligible without section 1115 authority (as defined by group 3 above).

Each yearly expenditure target for TennCare will be the sum of two budget components: (A) the projected cost of services by specified MEGs; and (B) the projected Disproportionate Share Hospital (DSH) adjustment. Each of these components has a distinct method for projecting costs into the future. Administrative costs under the demonstration will be excluded from the budget neutrality formula except as explained in Attachment D.

There are two steps involved in the calculation of the projected cost of services (A above) budget limit: determining baseline estimates of the number of Medicaid eligibles and the cost per eligible; and determining the method for inflating these estimates over time.

The initial per capita cost estimate will be based on the 1992 per capita costs of Medicaid eligibles, inflated to reflect SFY 2002 expenditures. That amount will be trended to cover SFY 2003 using the National Medicaid Health Expenditures trend rate. The per capita costs will be calculated for Children, Disabled, Adults over 65, and Other Adults. The 1992 and SFY 2003 monthly Per Member Per Month (PMPM) amounts for these groups and the specific growth rates for the PMPM amounts for remaining four years of the demonstration are listed below:

	PMPM Expenditures		**Annual Demonstration Trend Rates**			
	SFY 1992	SFY 2003/ DY-1	DY-2	DY-3	DY-4	DY-5
Children	$ 107.07	$ 230.19	7.98%	7.98%	7.98%	7.98%
Disabled	$ 339.57	$ 730.05	7.84%	7.84%	7.84%	7.84%
Over 65	$ 147.75	$ 317.64	6.18%	6.18%	6.18%	6.18%
Adults	$ 211.68	$ 455.09	7.75%	7.75%	7.75%	7.75%

The annual limit on Medicaid expenditures will be the sum of the DSH adjustment for that year and the products of the inflated per capita cost estimate for that year times the number of Medicaid eligibles (limited to those who would have been eligible without the demonstration, including optional populations that could have been authorized under State Plan Amendments) for each of the four eligibility groups.

The DSH adjustment is based on DSH payments made by Tennessee in 1992 and calculated in accordance with current law. The DSH adjustment for the initial year of the demonstration (SFY 2003) is $413,700,907. The DSH adjustment for each subsequent year shall be the previous demonstration year's adjustment trended by the CPI-U for that year, as published three months after the end of the demonstration year. In this manner, Tennessee will have available funding for DSH adjustments similar to other States. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation which impacts the calculation of DSH allotments.

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memorandums or regulation with respect to the provision of services covered under this demonstration. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

Budget neutrality will be determined over a five-year basis. Any annual savings from budget neutrality may only be applied to an eligibility expansion or to offset demonstration costs in excess of the annual budget limits during this period. The State must submit for CMS approval a waiver amendment requesting the expansion. In its amendment, the State must demonstrate that the expansion is sustainable, even when the accrued savings from this five-year waiver period are exhausted.

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of an individual waiver year, Tennessee will calculate annual expenditure targets for the completed year for each of the demonstration components. The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual amount claimed for FFP. Using the below schedule as a guide, if Tennessee exceeds these targets they shall submit a corrective action plan to CMS for approval.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

Attachment C

Access Standards

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum this shall include:

Primary Care Physician or Extender:

(a) Distance/Time Rural: 30 miles or 30 minutes

(b) Distance/Time Urban: 20 miles or 30 minutes

(c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.

(d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from the date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall note exceed 45 minutes.

(e) Documentation/Tracking requirements:

Documentation -- Plans must have a system in place to document appointment scheduling times. The State must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the survey required in special term and condition 4.

Tracking -- Plans must have a system in place to document the exchange of client information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

Specialty Care and Emergency Care:

Referral appointment to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts. Waiting times shall not exceed 45 minutes.

Hospitals:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

General Dental Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

General Optometry Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Pharmacy Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Lab and X-Ray Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Other:

All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary": access that is equal to or greater than the currently existing practice in the fee-for-service system.

Guidelines for State Monitoring of Plans

- The State will require, by contract, that Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.

- The State will monitor, on a periodic or continuous basis (but no less often than every 12 months), Plans' adherence to these standards, through the following mechanism: review of each plan's written QAP, review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes, and on-site monitoring of the implementation of the QAP standards.

- Recipient access to care will be monitored through the following State activities: periodic comparison of the number and types of providers before and after the demonstration, periodic surveys which contain questions concerning recipient access to services, measurement of waiting periods to obtain health care services, and measurement of referral rates to specialists.

Guidelines for Plan Monitoring of Providers

- Plans will require, by contract, that providers meet specified standards as required by the State contract.

- Plans will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

Attachment D

General Financial Requirements Under Title XIX

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the TennCare Demonstration).

2. a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.C., as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 6.

   b. For each demonstration year a Form CMS-64.9Waiver and/or 64.9PWaiver will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles (current and expansion) must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in Attachment B).

   c. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

   d. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

e. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Attachment A).

3. a. For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the Medicaid Eligibility Groups as defined in Attachment B for Group I – current eligibles and Group II – those who could be eligible for Medicaid if Tennessee amended its State Plan. Member months will not be provided for Group III – those who could not be eligible for Medicaid without Section 1115 authority. This information should be provided to CMS in conjunction with the quarterly progress report referred to in Item 13 of the Special Terms and Conditions. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the implementation date, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Attachment A).

   b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

4. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2.b. of this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State. The Forms CMS-37 and CMS-64 reports must clearly identify all categories of Medicaid and TennCare expenditures and revenues (i.e., cash MCO and BHO payments, supplemental pool payments, CPE, allowable IMD costs, FFP reductions related to TennCare premium collections, etc.).

   With regard only to hospital CPE described in 5.d. below, the State will report actual CPE within 12 months after the end of each fiscal year. At that time, the State will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year.

5. CMS will provide FFP at the applicable Federal matching rates for the following approved demonstration Waiver expenditures subject to the budget neutrality limits explained at Attachment B:

   a. The actual cash payments made by the State for TennCare covered services for each TennCare enrollee can generally be claimed by the State as a Medical Assistance Payment (MAP) at the Federal Medical Assistance Percentage (FMAP). However, during the periods that services are provided in accordance with MCO or BHO non-risk contracts, that portion of the State's payments that are for reimbursement of the non-risk contractors' administrative services can only be claimed by the State as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the State to reimburse the MCO or BHO non-risk contractors for services provided in accordance with non-risk contracts are costs of the demonstration waiver that are subject to the budget neutrality limitations explained at Attachment B.

   b. Actual cash disbursements made by the State from a supplemental pool to reimburse participating TennCare providers for their unreimbursed costs (including medical education costs) for TennCare covered services rendered to the enrollees, as well as those eligible but not enrolled (EBNE). CMS will only approve FFP for supplemental pool payments made in accordance with pool distribution methodologies that have been given prior CMS approval.

      Payments to providers that are not reimbursed based on cost, such as physicians, will be exempt from cost reconciliations.

   c. Actual cash disbursements made by the State from a supplemental pool to pay for Graduate Medical Education (GME) costs in accordance with the pool distribution methodology that has been given prior CMS approval.

   d. Actual expenditures certified by public hospitals (Certified Public Expenditures (CPE)) to have been incurred by those public hospitals for TennCare enrollees and those EBNE, but only to the extent that the State is able to document that the public hospital had an actual unreimbursed cost for providing those TennCare covered hospital inpatient and outpatient services which exceeded the amounts paid to that hospital from the following sources: the MCOs; the BHOs, the TennCare eligibles, TennCare supplemental pools, GME funds received from the GME universities that are for the reimbursement of costs incurred for the provision of the TennCare covered services, and other sources (except for local government indigent care funds).

e. Actual expenditures for providing services to a TennCare enrollee residing in an Institution for Mental Diseases (IMD) for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days and the following limitations:

Period	Allowable Portion of Expenditures
July 1, 2002 - June 30, 2003	100%
July 1, 2003 - June 30, 2004	100%
July 1, 2004 - June 30, 2005	100%
July 1, 2005 - June 30, 2006	50%
July 1, 2006 - June 30, 2007	0%

6. Report all administrative and service expenditures and revenue collections allowed under the waiver approved for this demonstration project in such a manner as agreed upon by the parties. Do not include expenditures related to research and evaluation activities. If the State requests, and if CMS approves Federal funding for such research and evaluation activities, then those expenditures may be funded under other Federal authority.

7. The State may include premiums collected as State matching funds, subject to the following restrictions:

Period	Allowable as State Share	Report as Collections
July 1, 2002 - June 30, 2003	80%	20%
July 1, 2003 - June 30, 2004	60%	40%
July 1, 2004 - June 30, 2005	40%	60%
July 1, 2005 - June 30, 2006	20%	80%
July 1, 2006 - June 30, 2007	0%	100%

Premiums that must be reported as collections should be reported on line 9.E. of the CMS-64 Summary Sheet.